DEPARTMENT OF HEALTH AND HUMAN SERVICES
HEALTH CARE FINANCING ADMINISTRATION

FORM APPROVED
OMB NO. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: HEALTH CARE FINANCING ADMINISTRATION

1. TRANSMITTAL NUMBER: 0 1 — 0 0 9

2. STATE: MONTANA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
HEALTH CARE FINANCING ADMINISTRATION
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE
01/01/01

5. TYPE OF PLAN MATERIAL *(Check One)*:

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☒ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate Transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION:

7. FEDERAL BUDGET IMPACT:
a. FFY 2001 $ 425,588
b. FFY 2002 $ 424,365

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT:
Attachment 4.19B, Pages 1-3, Service 2C
Attachment 4.19B, Pages 1-3, Service 2B

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*:
Attachment 4.19B Pages 1-2, Service 2C
Attachment 4.19B Pages 1-3, Service 2B

10. SUBJECT OF AMENDMENT:
Rural Health Clinics/Federally Qualified Health Clinics Reimbursement

11. GOVERNOR'S REVIEW *(Check One)*:

☐ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☒ OTHER, AS SPECIFIED:
SINGLE STATE AGENCY DIRECTOR

12. SIGNATURE OF STATE AGENCY OFFICIAL:

13. TYPED NAME:
Gail Gray

14. TITLE:
Director

15. DATE SUBMITTED:

16. RETURN TO:
Dept of Public Health & Human Services
Gail Gray, Director
Attn: Jean Robertson
PO Box 202951
Helena MT 59620-2951

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED:
April 2, 2001

18. DATE APPROVED:
6/8/01

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL:
1/1/01

20. SIGNATURE OF REGIONAL OFFICIAL:

21. TYPED NAME:
David Selleck

22. TITLE:
Acting Associate Regional Administrator

23. REMARKS:

POSTMARK: [redacted] March 30, 2001

2001 APR -2 P 2:40

FORM HCFA-179 (07-92)

Instructions on Back

MONTANA

REIMBURSEMENT FOR RURAL HEALTH CLINICS

All rural health clinic services will be reimbursed on a prospective payment system beginning with fiscal year 2001 with respect to services furnished on or after January 1, 2001 and each succeeding fiscal year. The prospective payment system will apply equally to provider based and independent (free-standing) rural health clinics.

A. PAYMENT FOR SERVICES PROVIDED BY RURAL HEALTH CLINICS

The payment limit for rural health clinic services will be as described in Section 1905(a)(2)(C) 42 U.S.C. 1396a.. For services furnished on or after January 1, 2001, payment for services for a rural health clinic shall be calculated on a per visit basis. This payment shall be equal to 100 percent of the average of the costs of the center or clinic of furnishing such services during the clinic's fiscal years 1999 and 2000 which are reasonable and related to the cost of furnishing such services. Resonableness shall be determined as the Secretary prescribes in regulations under section 1833(a)(3), or, in the case of services to which such regulations do not apply, the same methodology used under section 1833(a)(3) of the Social Security Act, adjusted to take into account any increase or decrease in the scope of such services furnished by the center or clinic during fiscal year 2001. The rural health clinic shall report any increase or decrease in the scope of services by filing a cost report for the center's fiscal year 2001 and subsequent fiscal years within 150 days after the close of the provider's reporting period.

The per visit payment rate shall include the costs of other ambulatory services. Allowable rural health clinic costs for other ambulatory services shall be determined in accordance with Medicare reasonable cost principles as set forth in 42 CFR Part 413 and Medicare rural health clinics allowable cost principles set forth in 42 CFR 405.2468, and HCFA manual provisions applicable to rural health clinics, including the Medicare provider reimbursement manual, HCFA Pub.15 and HCFA Pub. 27.

For services furnished during fiscal year 2002 or a succeeding fiscal year, the payment for such services will be in an amount (calculated on a per visit basis) that is equal to the amount of the perspective payment system per visit rate for the proceeding fiscal year (1) increased by the percentage increase in the Medicare Economic Index applicable to primary care services for that fiscal year, and (2) adjusted to take into account any increase or decrease in the scope of services furnished by the center during that fiscal year.

In the interim, the State will continue paying under it's current methodology, reimbursement is an all-inclusive rate per visit for Independent RHC's and the lower of 100% of charges or 100% of reasonable cost for Provider-Based RHC's, while transitioning to the BIPA 2000 requirements for Prospective Payment System by September 30, 2001. The State will reimburse RHC's to the requirements of BIPA retroactive to the effective date of January 1, 2001.

B. ESTABLISHMENT OF INITIAL YEAR PAYMENT FOR NEW RURAL HEALTH CLINICS
To determine the initial year Medicaid prospective payment system baseline for a newly qualified rural health clinic, reimbursement shall be equal to 100 percent of the costs of furnishing services

based on the prospective payment system rates for other clinics located in the same or adjacent area with a similar caseload. In the event that there is no such clinic, payment shall be made in accordance with the methodology for existing clinics established by the prospective payment system or based on other tests of reasonableness that the Secretary may specify.

Once the prospective payment system baseline for a new clinic is established, the clinics' per visit rate for years thereafter will be equal to the perspective payment system per visit rate for the proceeding fiscal year (1) increased by the percentage increase in the Medicare Economic Index applicable to primary care services for that fiscal year, and (2) adjusted to take into account any increase or decrease in the scope of services furnished by the clinic during that fiscal year.

C. SUPPLEMENTAL PAYMENTS IN CASE OF MANAGED CARE
In the case of services furnished by a rural health clinic pursuant to a contract between the clinic and a managed care entity (as defined in section 1932(a)(1)(B)), payment to the clinic shall be a supplemental payment equal to the amount (if any) by which the amount determined under Medicaid prospective payment system exceeds the amount of the payments provided under the contract.

The supplemental payment required shall be made at least quarterly. The department will request documentation from the providers of the type of services provided, the managed care payment amount per service made to provider, the number of visits provided, the provider's Medicaid reimbursement rate or amount for each type of service, total amount of the supplemental payment due to the provider, along with the recipient name, social security number and date of service. This notice will be sent to providers 20-30 days prior to the end of each quarter. The department will make payments due to providers, if any, within 30 days of receipt of the above information from the provider. If no information is provided to the department from the provider, this will be interpreted that no request for payment is being pursued.

D. ALTERNATIVE PAYMENT METHODOLOGIES

At its discretion the Department may provide for payment in any fiscal year to a rural health clinic for services described in section 1905(a)(2)(B) in an amount which is determined under an alternative payment methodology that (1) is agreed to by the Department and the clinic; and (2) results in payment to the clinic of an amount which is at least equal to the amount otherwise required to be paid to the center or clinic under the Medicaid prospective payment system.

REIMBURSEMENT FOR FEDERALLY QUALIFIED HEALTH CENTERS

All federally qualified health center services will be reimbursed on a prospective payment system beginning with fiscal year 2001 with respect to services furnished on or after January 1, 2001 and each succeeding fiscal year.

A. PAYMENT FOR SERVICES PROVIDED BY FEDERALLY QUALIFIED HEALTH CENTERS

The payment limit for federally qualified health center services will be as described in Section 1905(a)(2)(C) 42 U.S.C. 1396a. For services furnished on or after January 1, 2001, payment for services for a federally qualified health center shall be calculated on a per visit basis. This payment shall be equal to 100 percent of the average of the costs of the center or clinic of furnishing such services during the clinic's fiscal years 1999 and 2000 which are reasonable and related to the cost of furnishing such services. Resonableness shall be determined as the Secretary prescribes in regulations under section 1833(a)(3), or, in the case of services to which such regulations do not apply, the same methodology used under section 1833(a)(3) of the Social Security Act, adjusted to take into account any increase or decrease in the scope of such services furnished by the center or clinic during fiscal year 2001. The federally qualified health center shall report any increase or decrease in the scope of services by filing a cost report for the center's fiscal year 2001 and subsequent fiscal years within 150 days after the close of the provider's reporting period.

The per visit payment rate shall include the costs of other ambulatory services. Allowable federally qualified health center costs for other ambulatory services shall be determined in accordance with Medicare reasonable cost principles as set forth in 42 CFR Part 413 and Medicare federally qualified health centers allowable cost principles set forth in 42 CFR 405.2468, and HCFA manual provisions applicable to federally qualified health centers, including the Medicare provider reimbursement manual, HCFA Pub.15 and HCFA Pub. 27.

For services furnished during fiscal year 2002 or a succeeding fiscal year, the payment for such services will be in an amount (calculated on a per visit basis) that is equal to the amount of the perspective payment system per visit rate for the proceeding fiscal year (1) increased by the percentage increase in the Medicare Economic Index applicable to primary care services for that fiscal year, and (2) adjusted to take into account any increase or decrease in the scope of services furnished by the center during that fiscal year.

In the interim, The State will continue paying under it's current methodology, reimbursement is an all-inclusive rate per visit, while transitioning to the BIPA 2000 requirements for Prospective Payment System by September 30, 2001. The State will reimburse FQHC's to the requirements of BIPA retroactive to the effective date of January 1, 2001.

B. ESTABLISHMENT OF INITIAL YEAR PAYMENT FOR NEW FEDERALLY QUALIFIED HEALTH CENTERS

To determine the initial year Medicaid prospective payment system baseline for a newly qualified center, reimbursement shall be equal to 100 percent of the costs of furnishing services based on the prospective payment system rates for other centers located in the same or adjacent area with a similar caseload. In the event that there is no such center, payment shall be made in accordance with the methodology for existing centers established by the prospective payment system or based on other tests of reasonableness that the Secretary may specify.

Once the prospective payment system baseline for a new center is established, the health centers' per visit rate for years thereafter will be equal to the perspective payment system per visit rate for the proceeding fiscal year (1) increased by the percentage increase in the Medicare Economic Index applicable to primary care services for that fiscal year, and (2) adjusted to take into account any increase or decrease in the scope of services furnished by the center during that fiscal year.

C. SUPPLEMENTAL In the case of services furnished by a Federally-qualified health center pursuant to a contract between the center or clinic and a managed care entity (as defined in section 1932(a)(1)(B)), payment to the center or clinic shall be a supplemental payment equal to the amount (if any) by which the amount determined under Medicaid prospective payment system exceeds the amount of the payments provided under the contract.

The supplemental payment required shall be made at least quarterly. The department will request documentation from the providers of the type of services provided, the managed care payment amount per service made to provider, the number of visits provided, the provider's Medicaid reimbursement rate or amount for each type of service, total amount of the supplemental payment due to the provider, along with the recipient name, social security number and date of service. This notice will be sent to providers 20-30 days prior to the end of each quarter. The department will make payments due to providers, if any, within 30 days of receipt of the above information from the provider. If no information is provided to the department from the provider, this will be interpreted that no request for payment is being pursued.

D. ALTERNATIVE PAYMENT METHODOLOGIES

At its discretion the Department may provide for payment in any fiscal year to a federally qualified health center for services described in section 1905(a)(2)(C) in an amount which is determined under an alternative payment methodology that (1) is agreed to by the Department and the center; and (2) results in payment to the center of an amount which is at least equal to the amount otherwise required to be paid to the center under the Medicaid prospective payment system.